South Dakota Board of Nursing

South Dakota Department of Health
722 Main Street Suite 3, Spearfish, SD 57783
(605) 642-1388; FAX: 642-1389; WWW.STATE.SD.US/DOH/NURSING

Medication Administration Training Program for Unlicensed Assistive Personnel
Application for *Initial* Training Program

Medication administration may be delegated only to those individuals who have successfully completed a training program pursuant to ARSD 20:48:04.01:14. An application along with required documentation must be submitted to the Board of Nursing for approval. Written notice of approval or denial of the application will be issued upon receipt of all required documents. Send completed application and supporting documentation to the Spearfish BON address or fax above.

Name of Institution: _____

Name of Primary RN Instructor: _____

Address: _____

_____

Phone Number: _____ Fax Number: _____

E-mail Address of Faculty: _____

1. Request to use the following approved curriculum(s); submit a completed Curriculum Application Form for each selected curriculum. *Each program is expected to retain program records using the Enrolled Student Log form.*
   - ☐ 2011 South Dakota Community Mental Health Facilities (only approved for agencies certified through the Department of Social Services)
   - ☐ Gauwitz Textbook – Administering Medications: Pharmacology for Health Careers, Gauwitz (2009)
   - ☐ Mosby's Texbook for Medication Assistants, Sorrentino & Remmert (2009)
   - ☐ Nebraska Health Care Association (2010) (NHCA)
   - ☐ We Care Online
   - ☐ EduCare

2. Qualifications of Faculty/Instructor(s): Attach resumes / work history demonstrating two years of clinical RN experience.

3. List faculty and provide licensure information:

RN FACULTY/INSTRUCTOR NAME(S)	RN LICENSE			
	State	Number	Expiration Date	Verification *(Completed by SDBON)*

4. A **Certificate of Completion** will be provided by the Board of Nursing upon approval; the certificate must be completed and given to each successful student upon completion of the Medication Administration Training Program.

RN Faculty Signature: _____ **Date:** _____

This section to be completed by the South Dakota Board of Nursing

Date Application Received:	Date Notice Sent to Institution:
Date Application Approved:	Application Denied. Reason for Denial:
Expiration Date of Approval:	
Board Representative:	